



Recommendations for Preventive Pediatric Health Care

Northwest Primary Care recommends that you bring your child in for regular visits to assist in keeping your child healthy. Well-child visits allow your child’s Primary Care Provider (PCP) to monitor your child’s growth and development, give any vaccines that are due, and provide a chance to find and treat any concerns early. Well-child appointments are also a good time for you to ask any questions that you have about your child’s health and also give the PCP time to discuss age appropriate behavioral issues, including behaviors at the adolescent age.

Visit and Immunization chart

This chart lists important vaccines and tests as well as recommended well-child visits. In addition to these vaccinations, we recommend all children aged 6 months and older get a flu vaccine every fall.

AGE	Recommended office visits	Pediatric routine visit schedule
Birth	Well-child visit	Newborn blood screen Immunizations may be due
3-5 days	Well-child visit	
7-14 days	Well-child visit	2 nd PKU will be due (please bring in baby’s paperwork)
1 month	Well-child visit	Height, weight and head circumference check for proper growth
2 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
4 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
6 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
9 months	Well-child visit	Height, weight and head circumference check for proper growth Developmental screening
12 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental screening and blood draw
15-18 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental and Autism screening
2 years	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Autism screening, blood draw and BMI check
3 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
4 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure, vision and hearing check
5 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure, vision and hearing check
6, 8 and 10 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
11 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
12 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
13 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
14 and 15 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
16 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
17 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check



PEDIATRIC DEVELOPMENTAL SCREENING CONFIDENTIAL TEEN QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____ Male Female

Physician Signature: _____

Instructions: Please answer the questions below by choosing YES or NO.

Have you ever drank alcohol?	NO	YES
Have you ever taken things to get high, stay awake, calm down, or go to sleep?	NO	YES
Have you ever used marijuana?	NO	YES
Have you ever used drugs (cocaine, crack, heroin, ecstasy, meth, inhalants, or pills)?	NO	YES
Have you ever played games to make you pass out (choking game)?	NO	YES
Have you ever ridden in a car driven by someone (including yourself) who was high or had been using?	NO	YES
Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	NO	YES
Do you ever use alcohol while you are by yourself (alone)?	NO	YES
Do you ever forget things you did while using alcohol or drugs?	NO	YES
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	NO	YES
Have you ever gotten into trouble while you were using alcohol or drugs?	NO	YES
Have you pierced your body (not including ears) or gotten a tattoo?	NO	YES
Are you attracted to Males?	NO	YES
Are you attracted to Females?	NO	YES
Are you, or do you ever wonder if you are gay, lesbian, bisexual, or transgender?	NO	YES
Have you ever been forced or pressured to do something sexual that you didn't want to do?	NO	YES
Have you ever had sex (including intercourse or oral sex)?	NO	YES
Are you using a method to prevent pregnancy?	NO	YES
If yes, what method?		
Have you ever been pregnant or gotten someone pregnant?	NO	YES
Do you think you or your partner could have a sexually transmitted infection?	NO	YES
Are you worried about your mood?	NO	YES
Have you ever considered hurting yourself or someone else?	NO	YES
Has someone at home, school, or anywhere else made you feel afraid, threatened you, or hurt you?	NO	YES
Do you have other concerns you would like to discuss in private?	NO	YES